



Consent for Use and Disclosure Of Health Information

PATIENT GIVING CONSENT

Name: _____

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: Windy Lee Turner Telephone: 704-523-4515 Fax: 704-523-4006
Email: greatsmiles@dentalcarecharlotte.com
Address: 4525 Park Rd., B102, Charlotte, NC 28209

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

Drs. Pappert & Kirk Family Dentistry
4525 Park Road Suite B-102 Charlotte, NC 28209
704-523-4515 * Greatsmiles@dentalcarecharlotte.com

Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth _____	
_____ is authorized to release protected health information about the above named patient in the following manner and to identified persons.	
Entity to Receive Information. Check each person/entity that you approve to receive information.	Description of information to be released. Check each that can be given to person/entity on the left in the same section.
<input type="checkbox"/> Voice Mail	<input type="checkbox"/> Results of lab tests/x-rays <input type="checkbox"/> Other _____
<input type="checkbox"/> Other person (s) (provide name and phone number)	<input type="checkbox"/> Financial <input type="checkbox"/> Medical
<input type="checkbox"/> Email communication-Provide email address* _____ *For email communication to occur, please accept the disclosure below:	<input type="checkbox"/> Financial <input type="checkbox"/> Medical <input type="checkbox"/> Appointment reminders <input type="checkbox"/> Breach notification
<input type="checkbox"/> Text communication – Provide number * _____ *For text communication to occur, accept the disclosure below:	<input type="checkbox"/> Appointment reminder <input type="checkbox"/> Other: _____
<input type="checkbox"/> For email and/or text communication I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
<input type="checkbox"/> Photo of patient received by patient or legal guardian <input type="checkbox"/> Photo taken by staff (Example: pre/post procedure) <input type="checkbox"/> Other	<input type="checkbox"/> May be posted in office <input type="checkbox"/> May be posted on website <input type="checkbox"/> Other _____

Patient Rights: <ul style="list-style-type: none"> • I have the right to revoke this authorization at any time. • I may inspect or copy the protected health information to be disclosed as described in this document. • Revocation is not effective in cases where the information has already been disclosed but will be effective going forward. • Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law. • I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.
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This authorization will remain in effect until revoked by the patient.

_____ Date _____

Signature of Patient or Personal Representative
 *Description of Personal Representative's Authority (attach necessary documentation)